CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2011 FORM APPROVED OMB NO. 0938-0391

l l		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155328	B. WIN	G _		08/15/2	011
MAMEOUR	DROWINED OR GURDUTED			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			25 S B	OEHNE CAMP ROAD		
	RK REHABILITATIO		_		SVILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	IAG	DEFICIENCE		DATE
F0000	This visit was for Complaint IN000 Complaint IN000 Federal/state defi allegations are cir F328, and F329. Survey dates: 8/2 Facility number: Provider number: AIM number: 10 Survey team: Jer Census bed type: SNF: 13 SNF/NF: 79 Total: 92 Census payor typ Medicare: 12 Medicaid: 66 Other: 14 Total: 92 Sample: 5 These deficiencies	094580 - Substantiated. iciencies related to the ted at F157, F282, F309, 13 and 8/15/11 000221 : 155328 00267620 nnie Bartelt, RN	FO	TAG	The Preparation or execution this plan of correction does constitute admission of agreement by the provider of truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepare executed solely because it is required by federal and state. We respectfully request this of Correction serve as our allegation of compliance.	n of not of the ne d and s e law.	DATE
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JM4K11

Facility ID:

000221

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155328		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/15/2011	
	ROVIDER OR SUPPLIER		25 S BC	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Quality review concentration Cathy Emswiller	•			
F0157 SS=D	resident; consult wand if known, notification representative or a when there is an a resident which respotential for requiring significant changemental, or psychosocial status conditions or clinical ter treatment significant conditions or clinical ter treatment signification in the psychosocial status conditions or clinical ter treatment signification in the psychosocial status conditions or clinical ter treatment signification in the facility and the service of the facility as specified. The facility must a resident and, if known there is a change in resident state law or regular paragraph (b)(1) of the facility must resupdate the address	is in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or ent rights under Federal or actions as specified in			
	· ·	review and interview, the	F0157	F 157	09/12/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155328 08/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 25 S BOEHNE CAMP ROAD WESTPARK REHABILITATION CENTER EVANSVILLE, IN47712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE facility failed to ensure the physician was Resident C no longer resides at notified with results of a chest x-ray and the facility. abnormal breath sounds for 1 of 5 residents reviewed related to physician An audit was conducted to identify residents that have notification in a sample of 5. (Resident physician orders for x-rays and or C) nebulizer treatment over the last 30 days to ensure the physician Findings include: was notified of the x-ray results and notification of residents breath sounds according to the The clinical record for Resident C was physician order. reviewed on 8/13/11 at 12:25 p.m. Licensed staff have been Nursing Progress Notes for 7/8/11 at 2:30 re-educated on policy and procedure for "Physician p.m. indicated, "Chest X-ray today d/t Notification" and respiratory flow [due to] congestion. Family request tx to sheets. Physician orders for be routine. Triage will return call [symbol x-rays and respiratory treatments will be reviewed by the for with] orders regarding breathing tx Interdisciplinary Team to ensure [treatment]." physician notification was completed. Nursing Progress Notes for 7/8/11 at 2:40 p.m., indicated, "X-ray notified of order." DON/Designee will audit the Interdisciplinary Teams clinical review sheets 5 X weekly for 6 Nursing Progress Notes for 7/8/11 at 6:00 months to ensure follow through p.m., indicated, "N/O [new order] per on physician notification. triage. Albuterol Neb [nebulizer] tx BID Identified non compliance of physician notification will result in [twice a day] et [and] q [every] 4 [symbol 1:1 re-education with progressive for hours] prn [as needed]. Pharmacy discipline up to and including notified. Left message for family." termination. Results of the audits are reviewed by the QA committee for recommendations. Report of a chest x-ray, dated 7/8/11, indicated the document was faxed from Systemic changes will be radiology on 7/8/11 at 8:56 p.m. The completed by 9-12-11 report indicated, "Impression: Chest: Mild pulmonary vascular congestion in

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155328	B. WIN			08/15/2	011
					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIER	ę.		25 S BC	DEHNE CAMP ROAD		
	ARK REHABILITATI	ON CENTER			VILLE, IN47712		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
	_	fields. Comment:					
		ation is requested" A					
	1 ^	on the report indicated,					
	"7/9/11."						
	1	v on 8/15/11 at 11:30					
	a.m., in regard to	when the physician was					
	notified of the re	esults of the chest x-ray					
	for 7/8/11, the D	ON indicated the					
	physician would	have received the report					
	before the facilit	y so would have been					
	aware of the rep	ort when orders were					
	_	ulizer treatments twice					
	daily on 7/8/11 a	at 6:00 p.m.					
	1 *	failed to indicate the					
		ade aware of the results					
		y and need for clinical					
	correlation.	y and need for enmear					
	correlation.						
	The Respiratory	Treatment Record for					
	July 2011 for "A	lbuterol U/D [unit dose]					
	q 4 [symbol for]	hours] prn cough"					
	indicated the nel	oulizer treatment was					
	administered 7/9	9/11 at 8:00 a.m. and					
	included pulse a	nd respiratory rates and					
		wheezes and diminished,					
	before and after	·					
		failed to indicate the					
		otified of the wheezes and					
		th sounds. Other doses					
		ed one to two times daily					
	through 7/16/11, with indication of pulse						
	_	rates and breath sounds of					
		or diminished before					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328		(X2) M A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 08/15/2	ETED	
	PROVIDER OR SUPPLIEF		p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	after treatments.	lear/diminished or clear Documentation failed to sician was notified of the h sounds.					
	8:30 a.m., indicarehab dining. Cowalk. Placed in returned to room VS [vital signs] degrees] - 78 [purate]. O2 [oxyge [arrow pointing]	s Notes for 7/13/11 at ted, "Returning from blor pale. Unable to W/C [wheel chair] a put to bed. Denies pain. 124/66 - 98 [symbol for alse] - 32 [respiratory en] sat [saturation] 83 right] 91%. Lungs me] FNP here @ this					
	9:00 a.m. indicat @ 3 L/PNC [lite [intravenous] sta 1/2 NS @ [at] 60 normal saline] at	s Notes for 7/13/11 at red, "New orders. O2 on rs per nasal canula]. IV arted L [left] forearm. D5 o [dextrose 5%, one-half a 60 cc [cubic hour]. Family aware of					
	by the nurse pract "Subjective:P pain. Can't tell u coordinate extrest Objective: Some warm, ashy arou	dated 7/13/11 and signed etitioner, indicated, eatient moaning, denies as what is wrong. Can't mities to walk. e acute distresspale, and lips, does have a, Lungs: within normal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155328		A. BUILI	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/15/2	ETED	
NAME OF I	DDAVIDED OD GUDDI IED		B. WING		DDRESS, CITY, STATE, ZIP CODE	00/13/2	011
	PROVIDER OR SUPPLIER ARK REHABILITATION				DEHNE CAMP ROAD VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES	-	ID I	·		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
PREFIX TAG	limits/clear; rales coordination. W [recheck] about a color good, talkin with] family. Obreathing reg [regnon-laboredPlanecessary" Physician's order indicated, "O2 [of Keep sats greater 60/hr [sic]. Stat CBC [complete be metabolic profile with culture and A report of the clindicated, "Impressing littrate in the fieldComment lower lung field. otherwise essention of the clindicated, "Impressing littrate in the fieldComment lower lung field. otherwise essention of the clindicated, "Impressing littrate in the fieldComment lower lung field. otherwise essention of the clindicated, "Impressing littrate in the fieldComment lower lung field. otherwise essention of the clindicated, "Impressing littrate in the fieldComment lower lung field. otherwise essention."	Isc IDENTIFYING INFORMATION) [Sic]lack of muscular hen re [checkmark] in hour later, pt alert, ing & visiting [symbol for 2 still variable, but gular] & even, in: Recheck as [Sic]lack of muscular hen re [checkmark] in hour later, pt alert, ing & visiting [symbol for 2 still variable, but gular] & even, in: Recheck as [Sic]lack of muscular hen re gular alert, in hour later, pt alert, in hour later, pt alert, in hour later, pt alert, in hour later, in hour later, pt alert, in	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION DATE
	3.1-5(a)(2) 3.1-5(a)(3)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155328	A. BUILDING	00	COMPLETED 08/15/2011
		199926	B. WING		06/15/2011
NAME OF I	PROVIDER OR SUPPLIER		I	ADDRESS, CITY, STATE, ZIP CODE	
WESTPA	RK REHABILITATIO	ON CENTER		DEHNE CAMP ROAD VILLE, IN47712	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0282 SS=D	facility must be proin accordance with plan of care. Based on observation record review, the physicians' order treatments and streviewed related orders in a sample and F) Findings include 1. The clinical received on 8/13 A physician's order indicated, "Annu [every day] & propain." The Medication A (MAR) for the error of the propagation of the content of the propagation of the propagatio	ded or arranged by the ovided by qualified persons a each resident's written ation, interview, and a facility failed to ensure swere followed for macks for 3 of 5 residents to following physician's are of 5. (Residents B, C, are cord for Resident C was a fall at 12:25 p.m. Her, dated 7/26/11, sol cream to rectum qd in hemorrhoid or rectal and a facility for Annusol indicated with a circle around on	F0282	F 282 Resident C no longer resides the facility. Residents that haphysician treatment orders of 8-11-11 are currently being provided treatment per physician orders dated 8-9-1 mid morning and evening snare being given snacks per physician orders. Physician orders from the ladays were reviewed to ensure proper documentation and for through were completed. Curesidents are receiving treatments and snacks per physician orders. Facility staff were re-educate regarding following physician treatment orders and documentation. Physician or will be reviewed by the Interdisciplinary Team to identify the proper in the side of the s	ad lated ician I1 for lacks st 30 re collow rrent ed n rders

000221

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPI	
AND PLAN	OF CORRECTION	155328	A. BUI	LDING	00	08/15/2	
		100020	B. WIN			00/13/2	.011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WESTPA	RK REHABILITATIO	ON CENTER		1	DEHNE CAMP ROAD VILLE, IN47712		
					VILLE, IIV+11 12		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
	7/27 and 7/28/11	. Documentation failed			residents with orders with sn	acks.	
		eaning of the circles.			Dietary will audit the delivery	and	
		ted no nurse's initials to			cks		
		ication was administered			daily.		
	on 7/30/11. The				Administrator/Designee will		
		7/31 and 8/1 through			review audits 5 x weekly for	6	
		resident was discharged			months.	DOC	
	to another facility	•			Identified non compliance of will result in 1:1 re-education		
	to unother facility	,.			progressive discipline up to a		
	2 The clinical re	ecord for Resident B was			including termination. Result		
		3/11 at 11:30 a.m.			the audits are reviewed by the		
	Teviewed on 6/12	77 11 u t 11.30 u.m.			committee for recommendati	ions	
	An Ontometric F	Exam Form, dated			Systemic changes will be		
		d, "Reason for Visit			completed by 9-12-11		
	(Vision Quality):						
	(vibion Quanty).	Crusty rius.					
	A physician's ord	ler, dated 8/11/11,					
	1 ^ *	shampoo lid scrubs ou					
	· · ·	ery] a.m blepharitis					
	o.u."	33 1					
	A copy of the Tre	eatment Administration					
	1	on 8/13/11 indicated no					
	nurse's initials to	indicate the treatment					
	had been provide						
	•						
	A copy of the Tre	eatment Administration					
	Record received	on 8/15/11 indicated a					
	nurse's initials w	ith a circle around on					
	8/12/11, and a nu	rse's initials indicating					
		l been provided on					
		se's initials indicated the					
	treatment was pro	ovided on 8/14/11.					
	_	ailed to indicate an					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUI		INSTRUCTION 00	(X3) DATE COMPL	
		155328	B. WIN			08/15/2	011
	PROVIDER OR SUPPLIER			25 S BC	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
	explanation of the	e circled initials.					
	explanation of the During interview a.m., the DON in initials on the Mawas not administ should include ar medication was reduced at the Fassistant Director on 8/13/11 at 9:30. During interview a.m., Resident Fabed. She indicate her morning snace physician. She in a shower, was dishungry. She indicated she work sandwich for her The clinical reconsecutive on 8/13 interview. The rephysician's order make sure pt. [paramorning and even should be a sure pt	e circled initials. on 8/15/11 at 11:40 dicated the circled AR meant the medication ered and the MAR inidication of why the not administered. ame was included in a ble residents provided as Entrance Conference with or of Nursing [ADON] #2 0 a.m. on 8/13/11 at 10:45 was observed seated in ed she was waiting for ek as ordered by the indicated she had just had abetic, and was getting ficated she gets a the gets hungry. She uld prefer a lunch meat snack. ord for Resident F was fill immediately after the					
	snacks."						<u> </u>

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ) MULTIPLE CO	NSTRUCTION 00		(X3) DATE : COMPL		
		155328		BUILDING WING			08/15/2	011
		1	р. \		DDRESS, CITY, STA	TE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R			EHNE CAMP R			
WESTPA	ARK REHABILITATIO	ON CENTER		I	/ILLE, IN47712			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFI	ICIENCI)		DATE
	On 8/13/11 at 11	:00 a.m. ADON #1 was						
		st in obtaining Resident						
		ck. ADON #1 went to the						
		I could be heard asking						
		sident F's mid-morning						
		delivered to her. The staff						
		ndicating a sandwich had						
		or another resident but not						
		staff could be heard						
		would prepare and deliver make sure Resident F						
	was on the list fo							
	was on the list to	of snacks.						
	During interview	v on 8/15/11 at 1:20 p.m.,						
	Resident F indica	ated she had received no						
	snack on Saturda	ay or Sunday evenings						
	(8/13 and 8/14/13	1). She indicated the						
	dietary departme	ent had not delivered						
	snacks either eve	ening. She indicated she						
		on account of not having						
		ndicated on Sunday						
		se had bread and cheese						
	•	she preferred a lunch						
	l '	for a snack, but the nurse						
	told her the kitch							
	During interview	v on 8/15/11 at 1:25 p.m.,						
	_	ager indicated the evening						
	I -	ered to the nursing units at						
		last task before dietary						
	_	he evening. The Dietary						
		ed she could "pull on the						
	_	stem" the percentage of						
FORM CMS-2	2567(02-99) Previous Versio	-	JM4K	11 Facility I	D: 000221	If continuation sh	neet Pa	ge 10 of 26

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	A. BUIL	DING	NSTRUCTION 00	(X3) DATE: COMPL 08/15/2	ETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712	1 00 10.2	· · ·
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCE REGULATORY OR Snacks consumed on 8/15/11 at 1:5 Manager provided List and Care Trate of 8/8 through 8/2 indicated the resistance of more day snack consumindicated Resider peanut butter or of meat sandwich as meat sandwich as meat sandwich as meat sand [sal [slices] meat 1 sl. During interview on 8/15/11 at 3:0 indicated on Friday.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) I by the resident. To p.m., the Dietary d copies of the Snack acker record for the week 15/11. Care Tracker dent ate an average of snacks and no orning snacks. Id not indicate a day by mption. The Snack List at F was to receive cheese crackers and a s a morning snack and a s an evening snack. A st indicated, "Make sure andwiches] have 3 sl cheese unless stated."				TE.	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155328 08/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 25 S BOEHNE CAMP ROAD WESTPARK REHABILITATION CENTER EVANSVILLE, IN47712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Each resident must receive and the facility F0309 must provide the necessary care and services SS=D to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. F 309 Resident C no longer Based on record review and interview, the F0309 09/12/2011 resides at the facility. An audit facility failed to ensure care was provided was conducted to identify as ordered by the physician and residents that have a diagnosis of assessment and care planning related the hemorrhoids. Identified residents were assessed and bowel care resident's rectal pain were completed for plans and pain care plans were 1 of 1 resident reviewed related to rectal updated as needed. Staff were pain in a sample of 5. (Resident C) re-educated on performing assessments and updating bowel Findings include: and pain care plans/assessments. New physician orders will be reviewed The clinical record for Resident C was by the Interdisciplinary Team to reviewed on 8/13/11 at 12:25 p.m. ensure pain assessments and care plans are completed and updated. An audit will be A Progress Note, dated 7/26/11 and signed completed by the by the nurse practitioner, indicated, ADON/Designee 5 x weekly for "Subjective: ...Pt [patient] also C/O 6 months to ensure compliance. [complains of] rectal pain." "Objective" DON/designee will review audits 5 X weekly for 6 months. data indicated no examination related to Identified non compliance of the resident's rectum. "Assessment" assessments and care plans will indicated, "...Hemorrhoids." result in 1:1 re-education with progressive discipline up to and including termination. Results of A physician's order, dated 7/26/11, the audits are reviewed by the QA indicated, "Annusol cream to rectum qd committee for recommendations. [every day] & prn hemorrhoid or rectal Systemic changes will be pain." completed by 9-12-11 The Medication Administration Record (MAR) for the entry for Annusol indicated a nurse's initials with a circle around on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JM4K11

Facility ID:

000221

If continuation sheet

Page 12 of 26

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328		LDING	NSTRUCTION 00	(X3) DATE: COMPL 08/15/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP ROAD EVANSVILLE, IN47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	to indicate the medical indicated the control indicated the resident's recompanies about it. When it indicated indicated the indicated she wo since an assessm and the problem care plan. During indicated the circumeant the medical administered and	resident was discharged y. ction of the record dated adicate a care plan was a was planned related to tal pain and hemorrhoids. on 8/15/11 at 11:40 a.m. assment of the resident's emorrhoids, the DON the resident was a at or something was out would not document enterviewed as to whether morrhoids were internal entering, or if the pain was eatment, the DON tall need to ask the nurse, ent was not documented thad not been added to the grant the term of the point was not the MAR attion was not the MAR should include why the medication was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155328		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/15/2011	
	PROVIDER OR SUPPLIER		25 S B	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F0328	IN00094580. 3.1-37(a)	s related to Complaint nsure that residents receive			
F0328 SS=G	proper treatment a special services: Injections; Parenteral and en Colostomy, ureten Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on record facility failed to by family to have that the physician and that care was implemented for respiratory care. resulted in delay Evaluation result pneumonia. The affected 1 of 3 to respiratory car (Resident C) Findings include	teral fluids; ostomy, or ileostomy care; e; g; review and interview, the ensure a resident reported e a cough was assessed, in was contacted timely, is planned and management of the The deficient practice in medical evaluation. The deficient practice in treatment for deficient practice residents reviewed related are in a sample of 5.	F0328	F 328 Resident C no longer resident the facility. Audit was completed to idecurrent residents with physical orders for nebulizer treatmed lidentified residents were reassessed and physician notified of residents current condition to clarify and upocurrent physician orders a prescribed. Staff re-educated regarding respiratory flow sheets, pronotification of physician are notification will be indicated physician orders. Respirate sheets will be reviewed 5 to weekly for 6 months to ensproper documentation is completed and physician in	entify sicians nents. s were nt date s g oper nd when d per ory flow x sure

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155328	A. BUIL B. WING			08/15/2	011
			D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	₹			DEHNE CAMP ROAD		
WESTPA	RK REHABILITATI	ON CENTER			VILLE, IN47712		
					VILLE, IIVT7712		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	-	rs, dated 6/2/11, indicated			notified per orders and facili	ty	
	the resident was	prescribed Levaquin			policy.		
	(antibiotic) 500	milligrams twice daily for					
	pneumonia.						
	•				DON/Designee will review a	udits	
	Nursing Progres	s Notes, dated 6/29/11 at			5 x weekly for 6 months.		
		ed, "[Name], FNP			Identified non compliance of		
					will result in 1:1 re-education		
		ractitioner] seen [sic] pt			progressive discipline up to		
		/t [due to] family states			including termination. Result		
	_	and cough worried that			the audits are reviewed by to committee for recommendate		
	she may have pr	neumonia again. Cough			committee for recommendar	10113	
	@ night. [Syml	bol for no] new orders @			Systemic changes will be		
	this time."	2			completed by 9-12-11		
	******				, ,		
	A Progress Note	, signed by the nurse					
	_	_					
	•	dated 6/29/11, indicated					
		t with "Subjective: Pt.					
		owsy. Family reports					
	cough at night.	Nurses have not heard					
	cough. Pt. states	s she would 'sleep even					
	more if they wor	ald let me.'"					
	Ohiective data in	ndicated, "Recent vital					
	_	Lungs: Within normal					
		uses non-tender. Slight					
	amount of drain	- -					
	throatAssessn	nent: Cough not					
	significant. Leth	nargyPlan: Recheck:					
	As necessaryI	Drowsiness continues					
	=	n] behaviors stay stable					
		rrow pointing down]					
	Xanax. For now						
	Manax, Pul HOW	will Ouselve.					
	An Accident/Inc	ident Report, dated					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155328		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 08/15/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712	1 3 3 7 3 7 2	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	6/14/11, and Nur dated 6/14/11 at 9	sing Progress Notes, 9:00 a.m. and 10:00 p.m. dent's most recent vital					
	p.m. indicated, "C family (daughter) congestion & cou & neb [nebulizer Reported seen by physician] on 6/2 practitioner] on 6 [symbol for no] r info to [name of a am [morning]. R absence] [symbol Nursing Progress p.m. indicated, "I	Iname of attending (3/11 and [name of nurse (3/29/11 [symbol for with] new orders. Will send attending physician] in tesident LOA [leave of 1 for with] family." Notes for 7/4/11 at 1:30 Daughter notified that [name of attending					
	p.m. indicated, "7 States [name of a	Notes for 7/4/11 at 1:45 Friage returned call. ttending physician] ters received. Daughter					
	"Robitussin [cou [teaspoons] q [ev	s, dated 7/4/11, indicated, gh medication] 2 tsp ery] 4 [symbol for hours] ough" and "Albuterol					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155328		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/15/2	ETED	
	PROVIDER OR SUPPLIEF		p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	VICE, IIVI7712		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	U/D [unit dose] prn cough."	q 4 [symbol for hours]					
	Nursing Progres	s Notes for 7/4/11 failed					
	-	the resident returned					
	from leave of ab	sence with family on that					
	date. The Medic	cation Administration					
	Record (MAR) f	For 7/4/11 indicated the					
		l medications at the					
	facility on 7/4/11	1 at 8:00 p.m.					
	failed to indicate resident's vital si system, includin	n Nursing Progress Notes an assessment of the gns and respiratory g cough, breath sounds,					
	'	ration from 6/15 through gress Notes were recorded 17/8/11.					
	Documentation of	on the MAR and					
	Respiratory Trea	tment Record indicated					
		nebulizer treatment were					
		m 7/4/11 until 7/8/11 at					
	8:00 p.m.						
	in regard to local for vital signs an assessments, the (DON) indicated	e Director of Nursing d vital signs and sments would be in					
	Nursing Progres	s Notes for 7/8/11 at 2:30					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155328	B. WIN			08/15/2	011
		<u> </u>	P. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹			DEHNE CAMP ROAD		
WESTPARK REHABILITATION CENTER				1	VILLE, IN47712		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	p.m. indicated, "	Chest X-ray today d/t					
	congestion. Fan	nily request tx to be					
	routine. Triage	will return call [symbol					
	1	regarding breathing tx."					
		reguraning oreasining in:					
	Nursing Progres	s Notes for 7/8/11 at 2:40					
	p.m., maicated,	"X-ray notified of order."					
	Nursing Progres	s Notes for 7/8/11 at 6:00					
	"	"N/O [new order] per					
	1 ~						
	_	l Neb tx BID et [and] q 4					
	1	rs] prn. Pharmacy					
	notified. Left m	essage for family."					
	Donort of a char	at w raw datad 7/9/11					
	1 ^	st x-ray, dated 7/8/11,					
		cument was faxed from					
	1	/11 at 8:56 p.m. The					
	report indicated,	"Impression: Chest:					
	Mild pulmonary	vascular congestion in					
	both lower lung	fields. Comment:					
	_	ation is requested" A					
		on the report indicated,					
	"7/9/11."						
	''''						
	During interview	v on 8/15/11 at 11:30					
	-	when the physician was					
		esults of the chest x-ray					
		ON indicated the					
	· ·	have received the report					
	1 ^ *	•					
		y so would have been					
	_	ort when orders were					
		ulizer treatments twice					
	daily on 7/8/11 a	_					
	Documentation 1	failed to indicate the					

PRINTED: 09/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328		A. BUILD	DING	NSTRUCTION 00	(X3) DATE: COMPL 08/15/2	ETED	
		100020	B. WING		ADDRESS, CITY, STATE, ZIP CODE	00/13/2	011
NAME OF I	PROVIDER OR SUPPLIER				DEHNE CAMP ROAD		
WESTPA	RK REHABILITATION	ON CENTER		EVANS	VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
		ade aware of the results					
	^ *	and need for clinical					
	correlation.						
		n Nursing Progress Notes					
		/13/11 failed to indicate					
		spiratory assessment. No S Notes were recorded					
	from 7/8/11 until						
		.,,					
	The Respiratory	Treatment Record for					
	July 2011 for "A	lbuterol U/D q 4 [symbol					
		ugh" indicated the					
		ent was administered					
		m. and included pulse and					
		and breath sounds of					
		ninished before and after ocumentation failed to					
		ician was notified of the					
	breath sounds. C						
		to two times daily					
	through 7/16/11,	with indication of pulse					
		ates and breath sounds of					
		or diminished before					
		ear/diminished or clear					
		Documentation failed to					
	diminished breat	ician was notified of the					
		ailed to indicate an					
		ed to the need for the prn					
	doses of the nebu	_					
	The MAR indica	ted routine doses of the					
	Albuterol nebuliz	zer treatment were					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JM4K11

Facility ID: 000221

If continuation sheet

Page 19 of 26

INDIPITATION NOMBER 155328 NAME OF PROVIDER OR SUPPLIER WESTPARK REHABILITATION CENTER 0.4910 SUMMAY STATEMENT OF DEPICIENCIES OCHICARRY OR SUPPLIER WESTPARK REHABILITATION CENTER 0.4910 SUMMAY STATEMENT OF DEPICIENCIES OCHICARRY OR SUPPLIER OCHICARRY OR SUED PROVIDER OR SUPPLIER OCHICARRY OR SUED PROVIDER OR SUPPLIER OCHICARRY OR SUED PROVIDER OR SUPPLIER OCHICARRY OR SUPPLIER OCHICARRY OR SUPPLIER OCHICARRY OR SUPPLIER OCHICARRY REHABILITATION CENTER OCHICARRY OR SUPPLIER OCHICARRY O	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER WESTPARK REHABILITATION CENTER WESTPARK REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION) administered at S. 200 a.m. and S. 200 p.m. from 7/8/11 at 8:00 p.m. through 7/16/11 at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale, Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denice pain. VS [vital signs] 1/24/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started. I [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Carl t coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER WESTPARK REHABILITATION CENTER WESTPARK REHABILITATION CENTER SIMMARY STATEMENT OF DEFICIENCIES (GACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC (DENTPYING INFORMATION) TAG administered at 8:00 a.m. and 8:00 p.m. from 7/8/11 at 8:00 p.m. through 7/16/11 at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C (wheel chair) returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished, [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 ce per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Carl t coordinate extremities to walk. Objective: Some acuted distresspale, warm, ashy around lips, does have			155328				08/15/2	011
WESTPARK REHABILITATION CENTER WESTPARK REHABILITATION CENTER REGULATORY OR LSC DEVELOPED BY FULL TAG MANDRAY STATISTICS OF DEJECTION OR STATE TAG MANDRAY STATISTICS OF THE STATE TAG MANDRAY STATISTICS OF THE STATE TAG MANDRAY STATISTICS OF THE STATE TAG MANDRAY STATISTICS OF TAG MANDRAY STATISTICS MANDRAY STATIS				B. WIIV		ADDRESS CITY STATE ZIP CODE		
WESTPARK REHABILITATION CENTER EVANSVILLE, IN47712 SUMMARY STATEMENT OF DEFICIENCIES ID PROCESSES ILANG CORRECTION OSCIOLARIES ID OSCIOLARIES I	NAME OF I	PROVIDER OR SUPPLIEF	8					
PREFIX TAG REGULENCY MUST BE PERCEDED BY FILL REGULATORY OR LIC IDENTIFYING INFORMATION, and AND P. M. from 7/8/11 at 8:00 a.m. and 8:00 p.m. from 7/8/11 at 8:00 a.m. and 8:00 p.m. from 7/8/11 at 8:00 a.m. bocumentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 1/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 ec per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have	WESTPA	ARK REHABILITATI	ON CENTER		1			
TAG REGULATORY DELS IDENTIFYING INFORMATION) administered at 8:00 a.m. and 8:00 p.m. from 7/8/11 at 8:00 p.m. through 7/16/11 at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 9!%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have	(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
administered at 8:00 a.m. and 8:00 p.m. from 7/8/11 at 8:00 p.m. through 7/16/11 at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
from 7/8/11 at 8:00 p.m. through 7/16/11 at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 ce per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		administered at	8:00 a.m. and 8:00 p.m.					
at 8:00 a.m. Documentation failed to indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		from 7/8/11 at 8	00 p.m. through 7/16/11					
indicate assessments related to the routine treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have			-					
treatments Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have								
Nursing Progress Notes for 7/13/11 at 8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have			ents related to the routine					
8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		licatificity						
8:30 a.m., indicated, "Returning from rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		N · B	N. (5 7/10/11)					
rehab dining. Color pale. Unable to walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have								
walk. Placed in W/C [wheel chair] returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		•	•					
returned to room put to bed. Denies pain. VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		rehab dining. Co	olor pale. Unable to					
VS [vital signs] 124/66 - 98 [symbol for degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		walk. Placed in	W/C [wheel chair]					
degrees] - 78 [pulse] - 32 [respiratory rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		returned to room	put to bed. Denies pain.					
rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		VS [vital signs]	124/66 - 98 [symbol for					
rate]. O2 [oxygen] sat [saturation] 83 [arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		degrees] - 78 [pt	ılsel - 32 [respiratory					
[arrow pointing right] 91%. Lungs diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have								
diminished. [Name] FNP here @ this time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		1 2 2	, ,					
time." Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		1						
Nursing Progress Notes for 7/13/11 at 9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		I -	imej FNP nere @ tnis					
9:00 a.m. indicated, "New orders. O2 on @ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		time."						
@ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		Nursing Progres	s Notes for 7/13/11 at					
@ 3 L/PNC [liters per nasal canula]. IV [intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		9:00 a.m. indicat	ted, "New orders. O2 on					
[intravenous] started L [left] forearm. D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have								
D51/2 NS @ 60 [dextrose 5%, one-half normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		1 ~ -						
normal saline at 60 cc per hour]. Family aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		1	. ,					
aware of order." A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		_	•					
A Progress Note, dated 7/13/11 and signed by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have			60 cc per hour]. Family					
by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		aware of order."						
by the nurse practitioner, indicated, "Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		A Progress Note	dated 7/13/11 and signed					
"Subjective:Patient moaning, denies pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		_	_					
pain. Can't tell us what is wrong. Can't coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		1 * *						
coordinate extremities to walk. Objective: Some acute distresspale, warm, ashy around lips, does have		1	•					
Objective: Some acute distresspale, warm, ashy around lips, does have		1 ~	_					
warm, ashy around lips, does have								
		Objective: Som	e acute distresspale,					
occasional cough Lungs: within normal		warm, ashy arou	nd lips, does have					
occusional cough, Dango. Within normal		occasional cougl	n, Lungs: within normal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155328		(X2) M A. BUI		NSTRUCTION 00	COMPL	ETED	
		155328	B. WIN			08/15/2	U11
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD		
	RK REHABILITATIO			1	VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
PREFIX	limits/clear; rales coordination. Wan hour later, pt a wisiting [symb still variable, but ween, non-labor necessary" Physician's order indicated, "O2 at greater than 90% Stat [immediate] [complete blood metabolic profile with culture and with culture and A report of the chindicated, "Impressinfiltrate in the fieldComment lower lung field. otherwise essention of the chindicated, "Impressinfiltrate in the fieldComment lower lung field. otherwise essention, indicated, "Impressinfiltrate in the fieldComment lower lung field. otherwise essention, indicated, "Impressinfiltrate in the fieldComment lower lung field. otherwise essention, indicated, "Impression, indicated,"	cy MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) [Sici]lack of muscular then re [checkmark] about alert, color good, talking ol for with] family. O2 breathing reg [regular] bredPlan: Recheck as [Sici]lack of muscular then re [checkmark] about alert, color good, talking ol for with] family. O2 breathing reg [regular] bredPlan: Recheck as [Sici]Plan: Recheck as [Sici]		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
	This federal tag i IN00094580.	s related to Complaint					
	3.1-47(a)(6)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155328			(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/15/2011	
	PROVIDER OR SUPPLIER		STREET A 25 S BC	ODDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD VILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ſ
F0329 SS=D	from unnecessary drug is any drug we (including duplicate duration; or without adequate in the presence of account indicate the dose of the discontinued; or all reasons above. Based on a compart resident, the facility residents who have drugs are not give antipsychotic drug treat a specific condocumented in the residents who use gradual dose reduinterventions, unlein an effort to disconditional discondition	ug regimen must be free drugs. An unnecessary then used in excessive dose the therapy); or for excessive at adequate monitoring; or indications for its use; or in diverse consequences which should be reduced or my combinations of the rehensive assessment of a y must ensure that the not used antipsychotic in these drugs unless therapy is necessary to indition as diagnosed and acclinical record; and antipsychotic drugs receive ctions, and behavioral is clinically contraindicated, continue these drugs. The review and interview, the tensure the use of an	F0329	F 329 Resident C no longe resides at the facility. An au was conducted by the		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155328	B. WIN			08/15/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	DEHNE CAMP ROAD		
WESTPA	ARK REHABILITATI	ON CENTER		1	VILLE, IN47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1 * *	edication was indicated,			Interdisciplinary Team to ide		
	and failed to ens	sure an attempt at gradual			current residents on psychol medications to ensure gradu		
	dose reduction f	for 1 of 3 residents			dose reductions (GDR) are I		
	reviewed related	l to antipsychotic			preformed per State and Fe		
	medications in a	sample of 5. (Resident			regulations. Facility staff we		
	(C)	•			re-educated on documentati		
	Findings include	e:			resident behaviors and grad dose reductions. Interdiscipl Team will review the monthly psychopharmacological resi	inary y dent	
	The clinical reco	ord for Resident C was			utilization summary report th		
	reviewed on 8/1	3/11 at 12:25 p.m.			provided by the pharmacy to)	
		1			ensure a GDR is attempted unless contraindicated for co	ırrent	
	The record indic	cated the resident was			psychotropic medication res		
		facility on 11/23/10			are prescribed to ensure Sta		
		at a behavior unit upon			and Federal regulations are		
	1 -	_			followed. DON/designee will	audit	
		ocal hospital emergency			the Interdisciplinary Teams		
		had been taken by family			findings monthly for 6 month ensure GDRs are being	IS TO	
	1	o manage her care at			attempted unless contrainding	cated	
	home. The list	of the resident's home			Results of the audits are rev		
	medications on	the Psychiatric			by the QA committee for		
	Consultation, da	ated 11/13/10, did not			recommendations. Systemic		
	include the antiq	osychotic medication,			changes will be completed b	у	
	Zyprexa.				9-12-11		
	Physician orders	s upon admission					
	1 -	cription for one oral					
	Zyprexa 7.5 table	•					
	2,510.00 7.5 000	······································					
	The Mood and I	Behavior Symptom					
	Assessment/Plan	n of Care, originally dated					
		ost recently updated					
	1	the resident received					
	1	to the diagnoses of					
	1						
	Aizneimer's den	nentia with behaviors and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155328	A. BUII B. WIN			08/15/2	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	2		1	DEHNE CAMP ROAD		
WESTPA	ARK REHABILITATI	ON CENTER		EVANS'	VILLE, IN47712		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAG	+	LISC IDENTIFTING INFORMATION)	-	IAG	Dia relative 1		DATE
	psychosis.						
	The resident's "C	Compressed Mood and					
		" (a computer print out					
	1	navior monitoring) for					
		1 8/5/11, when the					
		charged to another					
	1	d the resident had no					
	behaviors.	d the resident had no					
	ochaviors.						
	A Consultation I	Report, dated 5/10/11					
		from the facility's					
	1	nacist, indicated,					
		me of Resident C] has					
	1	.5 mg QHS [every					
	1	nentia w/ [with] psychosis					
	and Trazodone 1						
		eral guidelines require					
	1 ^	ossible reduction at least					
	twice in the first						
		on. No behaviors noted					
	1	commendation: Please					
	consider a gradu	al dose reduction, perhaps					
	1	prexa 5 mg QHS					
	(continue Trazac	lone as currently ordered)					
		tly monitoring for					
	1	target and/or withdrawal					
	symptoms. If the	nerapy is to continue at					
	1 * *	please provide rationale					
	1	e reduction as clinically					
	contraindicated.	_					
	Recommendatio	n - The manufacturer's					
	prescribing infor	mation includes a					
	1 -	g which identifies a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JM4K11 Facility ID:

000221

If continuation sheet

Page 24 of 26

PRINTED: 09/08/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155328			ULTIPLE CO LDING	NSTRUCTION 00	COMPI	LETED
		100328	B. WIN			08/15/2	UII
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE DEHNE CAMP ROAD		
WESTPA	RK REHABILITATIO	ON CENTER		EVANS'	VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1 ^	ed risk of mortality in					
	medications of de	ls taking antipsychotic					
		lers. Federal nursing					
	facility regulation						
	, ,	ing used to manage					
		lize mood undergo					
		action (GDR) attempts in					
	~	rters within the first year					
		nt is admitted on one of					
		s or after the facility had					
		ication, then annually					
		SS CLINICALLY					
		ATED." A notation after					
		indicated a check mark					
		the recommendation(s)					
		DR is CLINICALLY					
	CONTRAINDIC						
	individual. The						
		ed or worsened after the					
		attempt within the					
		R attempt at this time is					
		his individual's function					
	or increase distre						
	DOCUMENTED	BELOW. Please					
	provide CMS [Co	enter for Medicare and					
	Medicaid Service	es] REQUIRED					
	patient-specific r	ationale describing why a					
	GDR attempt is 1	ikely to impair function					
	or increase behav	vior in this individual:"					
	Handwritten was	, "Still has behaviors at					
	time. [sic] Long	term depression." The					
	documentation w	as signed and dated by					
	the attending phy	vsician on 5/24/11.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JM4K11

Facility ID:

000221

If continuation sheet

Page 25 of 26

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 08/15/2	LETED
	PROVIDER OR SUPPLIER		25 S B0	ADDRESS, CITY, STATE, ZIP COD DEHNE CAMP ROAD VILLE, IN47712	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	the Social Service Director indicates behaviors since is Both indicated the redirected and very During interview in regard to follorelated to the absopossible gradual Resident C, the I indicated the physical been "on the mediding of the services of the	on 8/15/11 at 1:30 p.m. ow-up with the physician sence of behaviors and dose reduction for Director of Nursing visician thought she had dication so long he just see her off - he thought it				